

**FAMILY AND MEDICAL LEAVE ACT  
EMPLOYEE REQUEST FORM**

Date of Request: \_\_\_\_\_

Employee Name: \_\_\_\_\_

Personnel Number: \_\_\_\_\_

Home Address: \_\_\_\_\_

Street

City

LA

State

Zip Code

Home Telephone Number: \_\_\_\_\_

Office: \_\_\_\_\_

Division/Facility: \_\_\_\_\_

FMLA request is for: ☐ Self☐ To care for a family member

Name of family member: \_\_\_\_\_

Relationship: \_\_\_\_\_

If married, is your spouse a state employee? ☐ Yes ☐ No

Briefly explain reason for FMLA request \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Start date of anticipated leave: \_\_\_\_\_

Expected date of return: \_\_\_\_\_

Signature: \_\_\_\_\_

Date: \_\_\_\_\_